# KENTUCKY MEDICAID PROGRAM
# TARGETED CASE MANAGEMENT SERVICES CHILDREN MANUAL
# POLICIES AND PROCEDURES

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, Kentucky 40621

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

TARGETED CASE MANAGEMENT SERVICES CHILDREN MANUAL

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## SECTION I - INTRODUCTION

### A. Introduction

Effective July 1, 1991, the Kentucky.Medicaid Program began reimbursing providers for Targeted Case Management Services for Children. This manual has been formulated to provide you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual, Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, or Phone (800) 333-2188 or (502) 277-2525.

B. Fiscal Agent

Electronic Data Systems (EDS) is the. fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

# II. KENTUCKY MEDICAID PROGRAM

## A. General

The Kentucky Medicaid Program is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965 and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for improper payments to providers of non-covered, unallowable medical services.

The Kentucky Medicaid Program, Title XIX, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage is specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services', within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes payments to providers who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Social Insurance Offices, which are located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen (17) members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen (16) members are appointed by the Governor to four-year terms. Nine (9) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients, Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the recipient's medical expenses. The Medicaid Program is payor of last resort. Accordingly, the provider of service should seek reimbursement from third party groups for services provided. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount should be made to Medicaid, as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. These policies are as follows:

All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment. Stamped signatures are not acceptable.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

The provider's adherence to the application of policies in this manual is monitored through either post-payment review of claims by the Department or computer audits and edits of claims. If computer audits or edits fail to function properly the application of policies in this manual remain in effect and thus the claims become subject to post-payment review by the Department.

All claims and payments are subject to rules and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private pay patients and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given covered specialty.

Services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claim shall be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claim shall be paid for services that require, but do not have, prior authorization by the Kentucky Medicaid Program.

No claims shall be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall be attached to the Department and no bill for the same service shall be paid by the Department.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit'or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one (1) year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one (1) year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(l) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole ***or*** in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, **or** item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five (5) years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five (5) years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, ***or*** induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, nursing facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five (5) years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money ***or*** other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, nursing facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five (5) years, or both.

## III. Conditions of Participation

### A. General Information

Effective July 1, 1991, Targeted Case Management Services became available to Severely Emotionally Disturbed (SED) Children who are under age 21. Case management services are defined as services which will assist the targeted population (SED Children) in gaining needed access to medical, social, educational, and other support services.

### B. Provider Qualifications

Provider participation is limited to the fourteen (14) Regional Mental Health/Mental Retardation Centers, as licensed in accordance with the requirements set forth in 902 KAR 20:091, and to the Kentucky Department for Social Services.

The following participation forms are required to be completed by each provider of services:

(1) Provider Agreement (MAP-343)
(2) Provider Information Sheet (MAP-344)

After receipt of these completed forms, the Department for Medicaid Services (DMS) shall assign a provider number to be used for identification and billing purposes.

### C. Qualifications of Case Managers

The case manager shall have, at a minimum,

(1) A Bachelor of Arts or Science Degree in any of the behavioral sciences from an accredited institution. Elehavioral Sciences include psychology, sociology, social work, human services and special education; and

(2) One (1) year of experience in performing case management services or working directly with children. A Master's Degree in a behavioral science can substitute for the one (1) year of experience.

NOTE: Persons employed as Case Managers as of July 1, 1991, (the implementation date of this program) shall be considered "grandfathered", with regard to the one (1) year of experience requirement; however, the minimum educational requirement must be met. Anyone appointed to a case management position on or after July 1, 1991, shall meet the experience requirement.

(3) Completed a case management certification or training course, provided by the Department for Mental Health/Mental Retardation or the Department for Social Services, within six (6) months of his employment date; and

(4) In addition to the above, the case manager shall be supervised for one (1) year by a mental health professional; i.e. psychiatrist, psychologist, Master's level Social Worker (MSW), psychiatric nurse, or professional equivalent. A professional equivalent is defined as staff who have at least a Bachelor's degree in a behavioral science and two (2) years of experience in providing children's services. The supervisor shall also complete the required case management certification or training course.

Supervision is to be performed at least once a month, both individually (per client treatment plan) and in group (resource development).

(5) Case managers shall deliver only case management services, whether or not they are employed by the case management provider on a part-time *or* full-time basis.

(6) The recommended case load size is 15-20:1 for a full-time case manager. The maximum case load size shall be 25.

-- Interpersonal relationships: Defined as the ability to build and maintain satisfactory relationships with peer and adults;

-- Family life: Defined as the capacity to live in a family or family type environment;

-- Self direction: Defined as the child's ability to control his behavior and to make decisions in a manner appropriate to his **age**; and

-- Education: Defined as the ability to learn social and intellectual skills from teachers in an educational setting;

OR

(b) Is a Kentucky resident and is receiving treatment for emotional disturbance through the interstate compact;

OR

(c) The Department for Social Services has removed the child from the his home and has been unable to maintain the child in a stable setting due to behavioral or emotional disturbance(s);

**(4)** A child who presents impairment/behavior of short duration yet of high intensity. Included are severe emotional problems such as suicidal or psychotic trauma reactions where prognosis regarding duration of symptoms cannot be accurately assessed.

E. Client Records

Client records shall substantiate the services billed to Medicaid. Records shall include the type of case management service provided, the date of service, place of service, and the person providing the case management service.

Client records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments shall be maintained in an organized central file and furnished to the Cabinet for Human Resources upon request and made available for inspection and copying by Cabinet personnel.

All records shall be personally signed or co-signed and dated by the client's case manager.

The client's record shall designate in some manner the four (4) service contacts required each month for Medicaid Targeted Case Management billing. This shall be audited by post-payment review.

F. Termination of Provider Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting *or* concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standard;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render services to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice shall state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medicaid Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against a provider under Medicare shall be appealed through Medicare procedures.

IV. Services Covered

A. Definition of Case Management

Case Management services are defined as services which will assist the targeted population (SED children) in gaining needed medical, educational, social, and other support services. These services are performed by qualified case managers and shall include:

(1) A written comprehensive needs assessment which shall be obtained by face-to-face contact with the child, his family or other collaterals needed to determine the child's needs. The assessment shall include, but not be limited to, the following:

(a) Identifying information (formal caregivers, living arrangements, emergency contacts, source of assessment information, MAID #, if known);

(b) Family life (capacity to live in a family or family-type environment, interaction with family members);

(c) Physical health (note any health problems or concerns, treatments, medications, handicaps);

(d) Emotional health (behavior, alcohol/ substance abuse, intellectual functioning. This shall be further defined in the treatment plan.);

(e) Social relationships (informal caregivers, support, friends, family, volunteers, pets, recreation);

(f) Physical environment (safety, cleanliness, accessibility, etc.);

(g) Self-care (activities of daily living, ability to take care of one's own needs);

(h) Educational status (educational needs appropriateness/availability of needed educational programs, prognosis for future employment skills); and

(i) Legal status (guardian, those who exercise custodial control or supervision, involvement with the legal system, etc.).

2. Participation in the development of the child's treatment plan;

3. Coordination of and arranging for needed services as identified in the child's treatment plan;

4. Assisting the child and his family or person in custodial control in accessing needed services; (both Medicaid and non-Medicaid covered) as provided by a multiplicity of agencies and programs;

5. Monitoring the child's progress through the full array of services by

(a) Making referrals;

(b) Tracking the child's appointments;

(c) Removing any barriers which prohibit access to the recommended programs or services;

(d) Performing follow-up on services rendered to assure the services are received and meet the child's needs;

(e) Performing periodic re-assessments of the child's changing needs; and

(f) Educating the family or person in custodial control of the value of early intervention services and treatment programs.

6. Performing advocacy activities on behalf of the child. The case manager may intercede to assure appropriate, timely, and productive treatment modalities;

7. Establishing and maintaining current client records, documenting contacts, services needed, client's progress, and any other information as may be required;

a. Providing case consultations as required (i.e. consulting with a service provider to assist in determining the child's progress, etc.); and

9. Providing crisis assistance (i.e. intervention on behalf of the child, making arrangements for emergency referrals and treatment, and coordinating any other needed emergency services).

The treatment plan, developed in response to the case manager's needs assessment and other tests or procedures used for evaluation purposes by service providers, shall be monitored by the case manager.

While the case manager is not responsible for developing the child's treatment plan, it is the responsibility of the case manager to document
(1) all needed services,
(2) anticipated dates of delivery,
(3) services arranged,
(4) follow-up on services, and
(5) unmet needs and service gaps.

B. Limitations on Case Management Services

Case management services do not include:

(1) The actual provision of mental health or other services or treatments;

(2) Outreach activities to potential clients;

(3) Administrative activities associated with Medicaid eligibility determinations, processing, etc.;

(4) Institutional Discharge Planning - This service is required as a condition of payment for institutional (hospital, nursing facilities) services and therefore, shall not be covered under the Targeted Case Management Program. The case management provider may bill, however, for CASE MANAGEMENT services performed either in the month prior to or month of discharge from the facility to prepare for the child's return to the community;

(5) Transportation services solely for the purpose of transporting the child; and

**(6)** Case management services for children in out-of-state institutions or placements with **the** exception of the month prior to or the month **of** discharge and return to Kentucky.

(7) Payment shall not be made for case management services if the client participates in any Medicaid-covered case management program {i.e. Home and Community-Based (HCB) Waiver, Alternative Services for the Mentally Retarded (AIS/MR) Waiver, Hospice Program, or the Commission for Handicapped Children's Program).

**C.** Client Rights

**(1)** Clients shall have freedom of choice of case management services.(See Appendix X)

**(2)** Clients shall have freedom of choice of participating case management providers.

(3) Clients shall have freedom of choice of case managers employed by the case management provider.

(4) Clients shall be allowed to have free choice of service providers of any other Medicaid-covered services.

D. Regional Interagency Council (RIAC)

(1) Identification

All children seeking case management services under the Targeted Case Management Program shall be identified as severely emotionally disturbed (SED) children by the RIAC.

The agency referring the child to the RIAC for review is responsible for documenting that the child meets the criteria as stated in Section III, D. Client Qualifications of this manual.

An authorized representative from the referring agency shall sign the RIAC Form MAP-585 (See Appendix VI) as certification of the child's condition. The RIAC will review the completed MAP-585. The signature of the RIAC chairperson .on the MAP-585 will certify that the child has been identified as an SED child by the RIAC.

(2) Emergency Services

In the event of.an emergency (i.e. a child is in need of emergency case management services but the RIAC, due to meeting only monthly, does not meet timely enough to identify the child prior to needed services being rendered), the referring agency may provide case management services for up to four (4) weeks without the completion of the RIAC MAP-585 form. However, if the child is not identified by the RIAC at its next monthly meeting as an SED child, the referring agency may be at risk of providing services without receiving reimbursement.

(3) Documentation of Client Qualifications

It is the responsibility of the referring agency or other chosen case management provider to maintain all documentation regarding the child's DSM-III diagnosis, the RIAC MAP-585 form, and any other records that support the decision to provide Targeted Case Management Services for a particular child.

E. Assurance of Case Management Services Certification MAP-586 Form

After a child has been identified as an SED child by the RIAC, the referring agency or other chosen case management provider shall complete a MAP-586 Form. This form assures that the client.has had freedom of choice of not only case management services, but also a choice of all participating case management providers and case managers within a provider group, if applicable.

The referring agency, if chosen as the case management provider, shall retain a copy of this form in the client's files. A copy is to be given to the child's legal guardian or person in custodial control. If the referring agency assisting with completion of the form is not the chosen case management provider, the chosen provider shall retain a copy of the MAP-586 form in the client's file.

F. Out-of-Region or Out-of-State Short Term Placements

Children who meet all the requirements for targeted case management services and who are placed in out-of-region or out-of-state temporary or short term placements may be continued to be case managed by their "home" case management provider.

The requirement of four (4) service contacts per month is still required; at least one (1) contact shall be a face-to-face encounter with the child. However, it is recognized that a face-to-face encounter with the child in such placements may be difficult.

Therefore, while it is recommended that at least one (1) contact be a face-to-face encounter with the child, in this one instance, it is acceptable to substitute a telephone call to the child for the face-to-face contact. All other requirements regarding service contacts will apply.

## SECTION V - REIMBURSEMENT

V. Reimbursement

A. Payment

Reimbursement for Targeted Case Management Services for SED children shall be a cost-based system, utilizing an interim rate based on projected cost during the first year, with a year-end cost settlement. This methodology shall be reassessed prior to the beginning of year two.

Payment shall be made when four (4) service contacts have occurred during a month. Two (2) of the contacts shall be face-to-face; at least one (1) contact shall be with the child and the other with the parent or family or person in custodial control. **The other two** (2) contacts may be telephone or face-to-face contacts with or on behalf of the child. If there should be situations whereby multiple contacts are made on the same day, then the following procedures will be used: (1) if contacts are directly inter-related then all contacts would be counted as one contact; (2) If contacts are not directly interrelated then contacts would be counted as two contacts.

The unit of service shall be defined as one unit equaling one (1) month. The interim rate, for year one, shall be based on the provider's usual, customary, and reasonable charge up to a maximum of $200.00 per child per month. No more than one (I) payment per child per month shall be made and this payment shall represent payment in full for all case management services provided to the child during a month. The payment amount shall not vary with the nature or the-extent of the case management services being provided. The charge to the Medicaid Program shall be the same for all persons who receive-the same or similar service.

Appropriate documentation shall be maintained in the child's record of all case management services billed and performed.

B. Third Party Coverage

1. General

To expedite the Medicaid claims processing payment function, the provider of services shall actively participate in the identification of third party resources for payment on behalf of the client. At the time the provider obtains Medicaid billing information from the client, he shall determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid Program to function efficiently.

2. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program, all participating providers shall submit billings for medical services to a third party when the provider has prior knowledge that a third party may be liable for payment of the services.

In order to identify those clients who may be covered through a variety of health insurance resources, the provider shall inquire if the client meets any of the following conditions:

- If the client is married or working, inquire about possible health insurance through the client's or spouse's employer;
- If the client is a minor, ask about insurance the MOTHER, FATHER, or GUARDIAN may carry on the client;
- In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- Ask if the client has health insurance such as a CANCER, ACCIDENT, or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

Examine the client's MAID card for an insurance code. If the code indicates insurance coverage, question the client further regarding the insurance.

The following is a list of insurance codes found on the front of the MAID card:

A - Part A, Medicare only
B - Part B, Medicare only
C - Both Parts A and B Medicare
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
H - Health Maintenance Organization
J - Other and/or unknown
L - Absent Parent's insurance
M - None
N - United Mine Workers
P - Black Lung

3. Billing Instructions for Claims Involving Third Party Resources

If the client has third party resources that cover case management services, then the provider shall obtain payment or rejection from the third party before Medicaid is filed. If payment is received, the provider shall indicate on the claim form, in the appropriate field, the amount of the third party payment and the name and policy numbers of the health insurance covering the client. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim. Claims with attachments shall be non-electronic (paper) claims.

Exceptions:

*If the insurance company has not responded within 120 days of the date of filing the claim to them, the provider shall submit a the claim to EDS in the usual manner. A completed Third Party Liability (TPL) Lead Form which states "No Response in over 120 days" shall be attached to the claim. A copy of the TPL Lead Form can be found in the Appendix.

Forward the claim and attached TPL Lead Form to:

EDS
P. 0. Box 2009
Frankfort, KY 40602
ATTN: TPL Unit

*If proof of denial for the same client for the same or related services from the carrier is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six (6) months old.

*A letter from the provider indicating that he contacted the insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

4. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for payment shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting Medicaid payment shall be zero. Clients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers shall accept Medicaid payment as payment in full.

If a claim for a client is payable by a third party resource which was not pursued by the provider, the claim shall be denied. Along with a Third Party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number shall be indicated on the Remittance Statement. The provider shall pursue payment with this third party resource before billing Medicaid again.

If you have any questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: TPL Unit, or call (800) 333-2188.

5. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work-related incident, the provider shall pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as the names of attorneys, other involved parties, and the client's employer to the claim when submitting to EDS for Medicaid payment.

C. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Medicaid, whether due to erroneous billing or payment system faults, shall be refunded. Refund checks shall be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P. 0. Box 2009
Frankfort, KY 40602
ATTN: Financial Services Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and may result in prosecution.

## SECTION VI - COMPLETION OF CLAIM FORM

**VI.** Completion of Claim Form

A. General Information

1. Claims shall be submitted on the standard "Health Insurance Claim Form," (HCFA-1500, **(12/90).** Information entered on this form must be data entered for the claim to be processed; therefore, it is important that all information supplied is complete and legible. Typing the claim form is recommended, although clear, legible handwriting is acceptable. Claims may also be submitted electronically. Contact EDS to obtain instructions on how to bill electronically.

   According to Federal policy, claims shall be submitted to Medicaid within twelve (12) months of the date of service or within six (6) months of the Medicare payment date, whichever is longer.

2. Billing Instructions for Claims with Service Dates Over One Year Old

   Medicaid claims shall be filed within one (1) year of the date of service. Medicaid/Medicare -crossovers shall be filed within one (1) year of the date of service OR within six (6) months of the Medicare paid date, whichever is longer. To process claims beyond this limit you must attach, to EACH claim form involved, a copy of an in-process, paid, or denied claim remittance no more than twelve (12) months of age which verifies that the original claim was submitted within twelve (12) months of the service date.

   Copies of previously submitted claim forms, providers' in-house records of claim submittals, and letters which merely detail filing dates are NOT acceptable documentation of timely billing. Attachments shall prove that the claim was RECEIVED in a timely manner by EDS.

If a claim is being submitted after twelve (12) months from the date of service, due to the recipient's retroactive eligibility, a copy of the backdated or retroactive MAID card shall be attached to the claim form.

3. MAID Number

The client's Kentucky Medicaid Identification (MAID) card should be checked carefully to verify the ten (10)-digit MAID number, the client's name, and that the card is valid for the period of time during which services are provided. "Eligibility Period" on the MAID card may show month-to-month eligibility (e.g. from 07/01/91 to 08/01/91), retroactive eligibility (e.g. from 06/01/90 to 08/01/91), or specific dates of eligibility (e.g. from 07/20/91 to 08/01/91). The "To" date is not an eligible date. Payment cannot be made for services provided to an ineligible person.

4. Medicaid Provider Number

All provider records, including Remittance Statements and payments, are maintained by the computer system by provider number. The correct eight (8)-digit Kentucky Medicaid Provider Number shall be entered on the claim form in field #33 of the HCFA-1500 (12/90) form to ensure notification of the status of the claims and correct payment. An incorrect or missing number could result in payment to another provider if the number is a valid provider number, or failure of the claim to receive payment. Since the Remittance Statements contain, information about claims by provider number, claims with invalid provider numbers will not appear *on* Remittance Statements.

5. Procedural Coding for Case Management

The procedure code for Case Management services is X0064. Use of this code is limited to one (1) unit per month, per client, per provider; however, the number of service contacts per month is unlimited.

B. Instructions for Completion of the HCFA-1500 Claim Form

A copy of the HCFA-1500 claim form can be found in Appendix V of this manual.

Claims forms can be ordered from:

U.S. Goverment Printing Office
Superintendent of Documents
Washington, D.C. 20402

Telephone: l-800-621-8335

## SECTION VI - COMPLETION OF CLAIM FORM

**24B** PLACE OF SERVICE

Enter the appropriate two (2)-digit place of service code. The place of service code for case management service is- 99.

**24D** PROCEDURE CODE

Enter the five (5) digit procedure code X0064.

**24E** DIAGNOSIS CODE INDICATOR

Transfer "1", "2", "3", or "4" from field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.

**24F** PROCEDURE CHARGE

Enter your ususal and customary charge for case man agement services.

**24H** EPSDT FAMILY PLAN

Enter a "Y" if the treatment rendered was a direct result of the Early and Periodic Screening, Diagnosis and Treatment Program.

**26** PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key the first eight or fewer digits. This number will appear on the Remittance Statement as the invoice number.

**28** TOTAL CHARGE

Enter the total charges from all lines of the claim.

**29** AMOUNT PAID

Enter the amount received by private insurance. If no private insurance payment, leave blank.

## SECTION VI - COMPLETION OF CLAIM FORM

30 BALANCE DUE

Enter the amount received form Medicare, if any, otherwise, leave blank.

31 SIGNATURE/INVOICE DATE

The actual signature of the provider or the provider's appointed representative is required. Stamped signatures are not acceptable.

33 PROVIDER NUMBER

Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight (8)-digit individual Medicaid provider number.

Send the completed original HCFA-1500 (12/90) claim form to EDS for processing as soon as possible after the service is provided. Retain a copy in your files.

Mail completed claims to:

EDS
P.O. Box 2018
Frankfort, Ky 40602

**A.** Correspondence Forms Instructions

| TYPE OF INFORMATION REQUESTED | TIME FRAME FOR INQUIRY | MAILING ADDRESS |
|---|---|---|
| Inquiry | 6 weeks after billing | EDS<br>P.O. Box 2009<br>Frankfort, KY 40602<br>ATTN: Provider Relations Unit |
| Adjustment | Immediately | EDS<br>P.O. Box 2009<br>Frankfort, KY 40602<br>ATTN: Financial Services Unit |
| Refund | Immediately | EDS<br>P.O. Box 2009<br>Frankfort, KY 40602<br>ATTN: Financial Services Unit |

| TYPE OF INFORMATION REQUESTED | NECESSARY INFORMATION |
|---|---|
| Inquiry | 1. Completed Inquiry Form<br>2. Remittance Statement and Medicare EOMB, when applicable<br>3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on a Remittance Statement within a reasonable amount of time |

| TYPE OF INFORMATION REQUESTED | NECESSARY INFORMATION |
|---|---|
| Adjustment | 1. Completed Adjustment Form<br>2. Corrected claim<br>3. Photocopy of the applicable portion of the Remittance Statement in question |
| Refund | 1. Refund Check<br>2. Photocopy of the applicable portion of the Remittance Statement in question<br>3. Reason for refund |

B. Telephoned Inquiry Information

WHAT IS NEEDED?

-Provider number
-Patient's Medicaid ID number
-Date of service
-Billed amount
-Your name and telephone number

WHEN TO CALL?

-When a claim is not showing on paid, pending or denied sections of the Remittance Statement within 6 weeks
-When the status of claims are needed and they do not exceed five in number

WHERE TO CALL?

-Toll-free number l-800-333-2188 (within Kentucky)
-Local (502) 227-2525

c. Filing Limitations

| | |
|---|---|
| NEW CLAIMS | 12 months from date of service |
| MEDICARE/MEDICAID CROSSOVER CLAIMS - | 12 months from date of service<br><br>NOTE: If the claim is received by EDS more than 12 months from date of service, but less that 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing. |
| THIRD-PARTY LIABILITY CLAIMS - | 12 months from date of service<br><br>NOTE: If the insurance company has not responded with 120 days of the date a claim is submitted to the insurance company, submit the claim and Third Party Lead Form to EDS indicating "NO RESPONSE within 120 days" from the insurance company. |
| ADJUSTMENTS | 12 months from the date the paid claim appeared on the Remittance Statement |

D. Provider Inquiry Form

The Provider Inquiry Form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry Form should be completed for each status request.) The Provider Inquiry Form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry Form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at l-(800)-333-2188 or l-(502)-227-2525.

Please remit BOTH copies of the Provider Inquiry Form to EDS. Any additional documentation that would help clarify. your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is NOT necessary to complete a Provider Inquiry Form when resubmitting a denied claim.

Provider Inquiry forms may NOT be used in lieu of Medicaid claim forms, adjustment forms, or any other document required by Medicaid.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry Form are found on the next page.

Following are field by field instructions for completing the Provider Inquiry Form:

| FIELD NUMBER | INSTRUCTIONS |
|---|---|
| 1 | Enter your 8-digit Kentucky Medicaid Provider Number. |
| 2 | Enter your Provider Name and Address. |
| 3 | Enter the Medicaid Recipient's Name as it appears on the Medical Assistance Identification Card. |
| 4 | Enter the recipient's lo-digit Medicaid number. |
| 5 | Enter the Billed Amount of the claim on which you are inquiring. |
| 6 | Enter the Claim Service Date(s). |
| 7 | If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Statement listing the claim. |
| 8 | If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Statement for that particular claim. |
| 9 | Enter your specific -inquiry. |
| 10 | Enter your signature and the date of the inquiry. |

E. Adjustment Request Form

The Adjustment Request Form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. A CORRECTED CLAIM AND THE APPROPRIATE PAGE OF THE REMITTANCE STATEMENT SHALL BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

| FIELD NUMBER | DESCRIPTION |
|---|---|
| 1 | Enter the 13-digit claim number for the particular claim in question. |
| 2 | Enter the client's name as it appears on the Remittance Statement (last name first). |
| 3 | Enter the complete client's MAID number as it appears on the Remittance Statement. The complete Medicaid number contains 10 digits. |
| 4 | Enter the provider's name, address and complete provider number. |
| 5 | Enter the "From Date of Service" for the claim in question. |
| 6 | Enter the "To Date of Service" for the claim in question. |
| 7 | Enter the total charges submitted on the original claim. |

| FIELD NUMBER | DESCRIPTION |
|---|---|
| 8 | Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the Remittance Statement. |
| 9 | Enter the Remittance Statement date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted. |
| 10 | Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service). |
| 11 | Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid). |
| 12 | Enter the name of the person who completed the Adjustment Request Form. |
| 13 | Enter the date on which the form was submitted. |

Mail the completed Adjustment Request Form, a corrected claim, and Remittance Statement to the address on the top of the form.

To reorder these forms, contact the Provider Relations Unit:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

# VIII. REMITTANCE STATEMENT

## A. General

The EDS Remittance Statement (or Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by Medicaid with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by Medicaid with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appear on the Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

## SECTION VIII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix VII-P.l. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

### EXPLANATION OF REMITTANCE STATEMENT FOR PROVIDER SERVICES

| ITEM | |
|---|---|
| INVOICE NUMBER | The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference |
| RECIPIENT NAME | The name of the recipient as it appears on the Department's file of eligible Medicaid recipients |
| RECIPIENT NUMBER | The Medicaid I.D. Number of the recipient as shown on the claim form submitted by the provider |
| INTERNAL CONTROL NO. | The internal control number (ICN) assigned to the claim for identification purposes by EDS |
| CLAIM SVC DATE | The earliest and latest dates of service as shown on the claim form |
| TOTAL CHARGES | The total charges billed by the provider for the services on this claim form |
| CHARGES NOT COVRD | Any portion of the provider's billed charges that are not being paid, (examples: rejected line item, reduction in billed amount to allowed charge) |
| AMT. FROM OTHER SRCS | The amount indicated by the provider as received from a source other than the Medicaid Program for services on this claim |

| | |
|---|---|
| CLAIM PMT AMOUNT | The amount being paid by the Medicaid Program to the provider for this claim |
| EOB | For explanation of benefit code, see the back page of Remittance Statement |
| LINE NO. | The number of the line on the claim being printed |
| PS | Place of service code depicting the location of the rendered service |
| PROC | The procedure code in the line item |
| QTY | The number of procedures/supply for that line item charge |
| LINE ITEM | The charge submitted by the provider for the CHARGE procedure in the line item |
| LINE ITEM PMT | The amount being paid by the Medicaid Program to the provider for a particular line item |

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix VII.-P.2.

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix VII-P.3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims in Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statement (Appendix VII-P.4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities. (Appendix VII-P.4).

CLAIMS PAID/DENIED the total number of finalized claims which have been determined to be denied or paid by the Medicaid Program, as of the date indicated on the Remittance Statement and YTD summation of claim activity

AMOUNT PAID the total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity

| | |
|---|---|
| WITHHELD AMOUNT | the dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies) |
| NET PAY AMOUNT | the dollar amount that appears on the check |
| CREDIT AMOUNT | the dollar amount of a refund that a provider has sent in to EDS to adjust-the 1099 amount (this amount does not affect claims payment; only adjusts the 1099 amount) |
| NET 1099 AMOUNT | the total amount of money that the provider has received from the Medicaid Program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds |

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appears on the dated Remittance Statement has a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix VII-P.5).

DEPARTMENT FOR MEDICAID SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but include cleanings, oral examinations, X-rays, filling, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to recipients under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-first (21) birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

Medical History
Physical Examination
Growth and Development Assessment
Hearing, Dental, and Vision Screenings
Lab tests as indicated
Assessment or Updating of Immunizations

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

HEARING SERVICES

Hearing evaluations and single hearing aides, when indicated, shall be paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as 'check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aid services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services shall not be limited by age.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment

to the patient's illness and death. A Medicaid recipient who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorized by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of Program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age one (1) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid.

OUTPATIENT SERVICES

Benefits of' the Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

LONG TERM CARE FACILITY SERVICES

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

MENTAL HOSPITAL SERVICES

Reimbursement is available for inpatient psychiatric services provided to Medicaid recipients under age twenty-one (21) and recipients who are age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism,

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Therapeutic Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health centers and possibly avoid hospitalization. There are fourteen (14) major centers, with satellite centers available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid coverage shall be available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up post partum visits within four (4) to six (6) weeks of the delivery date.

NURSE PRACTITIONER

Services by an Advanced Registered Nurse Practitioner shall be payable if the services provided is within the scope of licensure.

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medicaid Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities. The Drug List is distributed quarterly with monthly updates.

Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be covered for payment through the Drug Prior Authorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs, selected vaccines and Rhogam), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

PHYSICIAN SERVICES (CONTINUATION)

Limited coverage:

Certain types of office exams, such as comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be covered only for certain medical conditions where the care requires professional supervision.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal free-standing dialysis center service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicles if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients,

DEPARTMENT FOR MEDICAID SERVICES

**SPECIAL PROGRAMS**

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medicaid Only shall be covered under KenPAC. The recipient shall choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medicaid Identification Card each time a service is received.

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

The Alternative Intermediate Services for the Mentally Retarded (AIS/MR) home and community-based services program provides coverage for an array of community based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD).

HOME AND COMMUNITY-BASED WAIVER SERVICES

A home and community-based services program provides Medicaid coverage for a broad array of home and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

SPECIAL HOME AND COMMUNITY-BASED SERVICES MODEL WAIVER PROGRAM

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

## ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medicaid Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

## ELIGIBILITY INFORMATION

### MAID Cards

Medicaid Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

### Verifying Eligibility

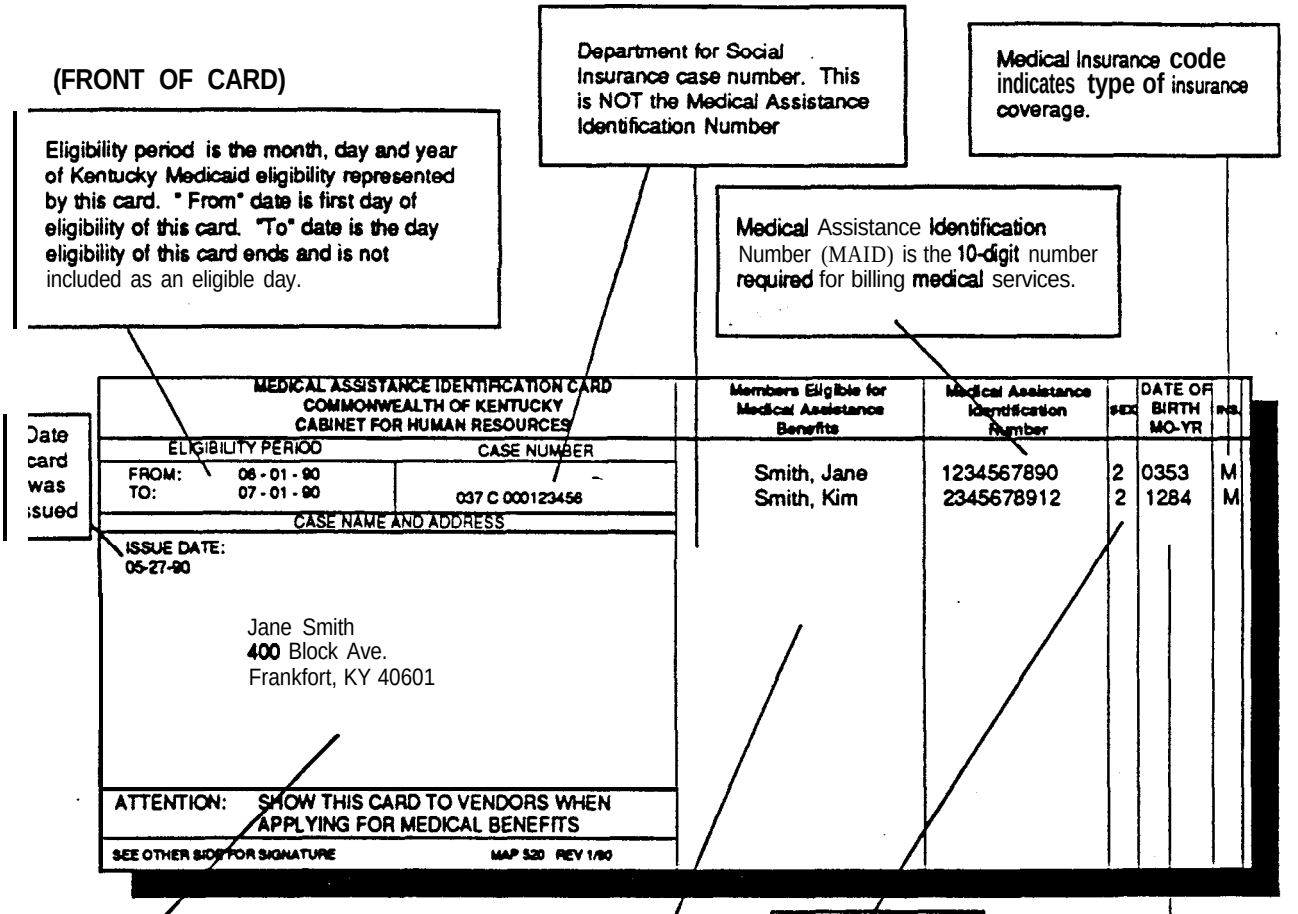
The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

**CABINET FOR HUMAN RESOURCES**
**DEPARTMENT FOR MEDICAID SERVICES**

## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)




Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Date card was issued

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For Kentucky Medicaid Program Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names am in this block are eligible for Kentucky Medicaid Program benefits.

Date of Bii shows month and year of birth of each member. Refer to this block when pmvidiig services limited to age.

# WHITE CARD

**CABINET FOR HUMAN RESOURCES**
**DEPARTMENT FOR MEDICAID SERVICES**

## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

**(BACK OF CARD)**

**Information to** Providers. **Insurance Identification codes indicate type of insurance coverage as shown** on **the** front of he cad in ***'ins.'*** **block.**

**PROVIDERS OF SERVICE**

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621-0001

**Insurance Identification**

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B-Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

**RECIPIENT OF SERVICES**

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205. 624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

**Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who wilfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.**

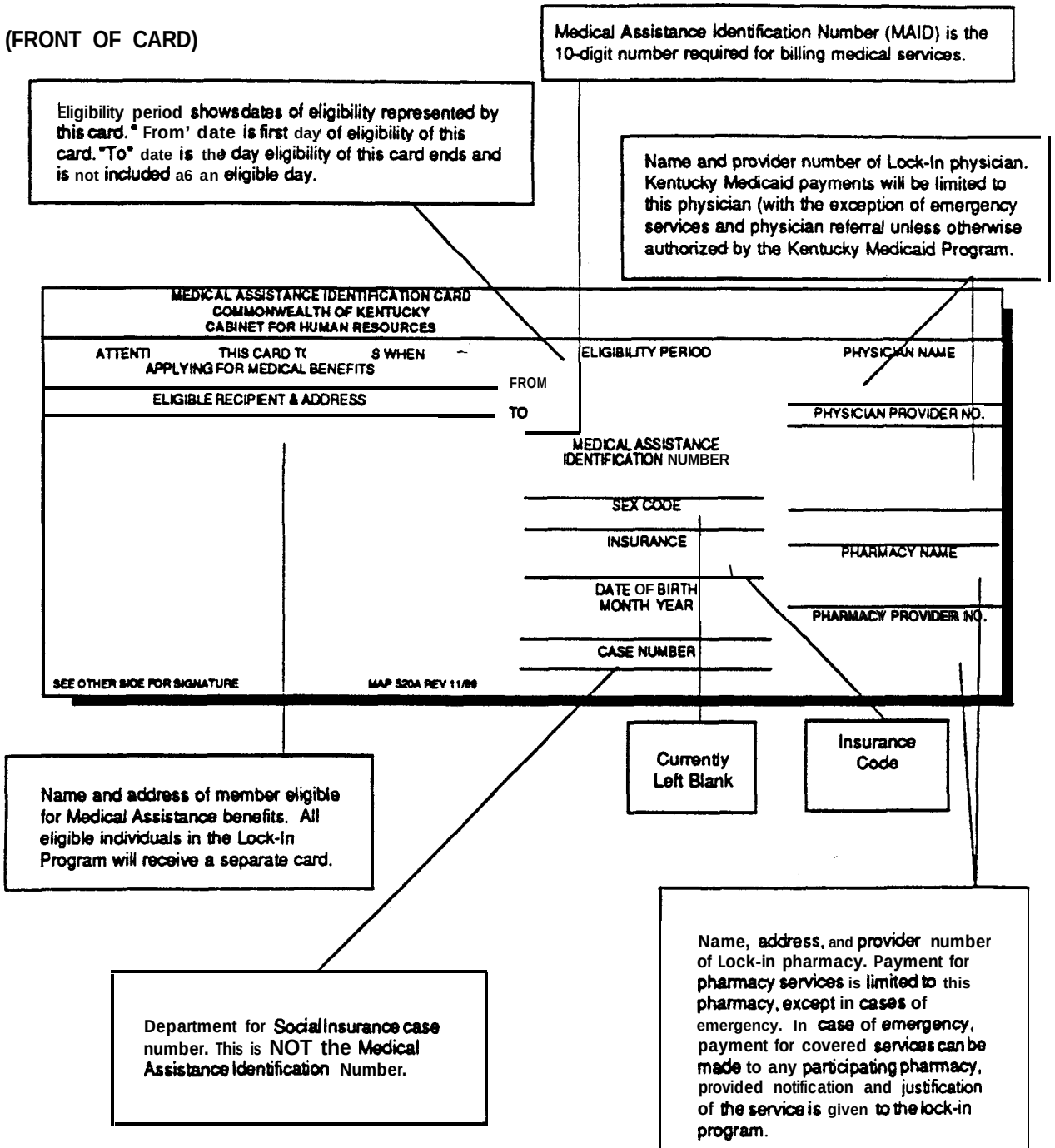
**Notification** to recipient of assignment to **the Cabinet** for Human **Resources** of hi **party** payments.

**Recipient's signature is not required.**

**CABINET FOR HUMAN RESOURCES**
**DEPARTMENT FOR MEDICAID SERVICES**

## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)




PINK CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers. induding procedures for emergency treatment, and identification of insurance as shown on the front of the card in 'Ins.' block.

## ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. Questions regarding scope of services should be directed to the Lock-In Coordinator by calling 502-564-5560.

You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

A- Part A Medicare Only
R- Part A, Medicare Premium Paid
B- Part B Medicare Only
C-Both Parts A & B Medicare
S- Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E- Blue Cross Blue Shield Major Medical
F- Private Medical Insurance
G-Champus
H- Health Maintenance Organization
J- Unknown
K- Other
L- Absent Parent's Insurance
M-None
N- United Mine Workers
P- Black Lung

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

## RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

**CABINET FOR HUMAN RESOURCES**
**DEPARTMENT FOR MEDICAID SERVICES**

## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

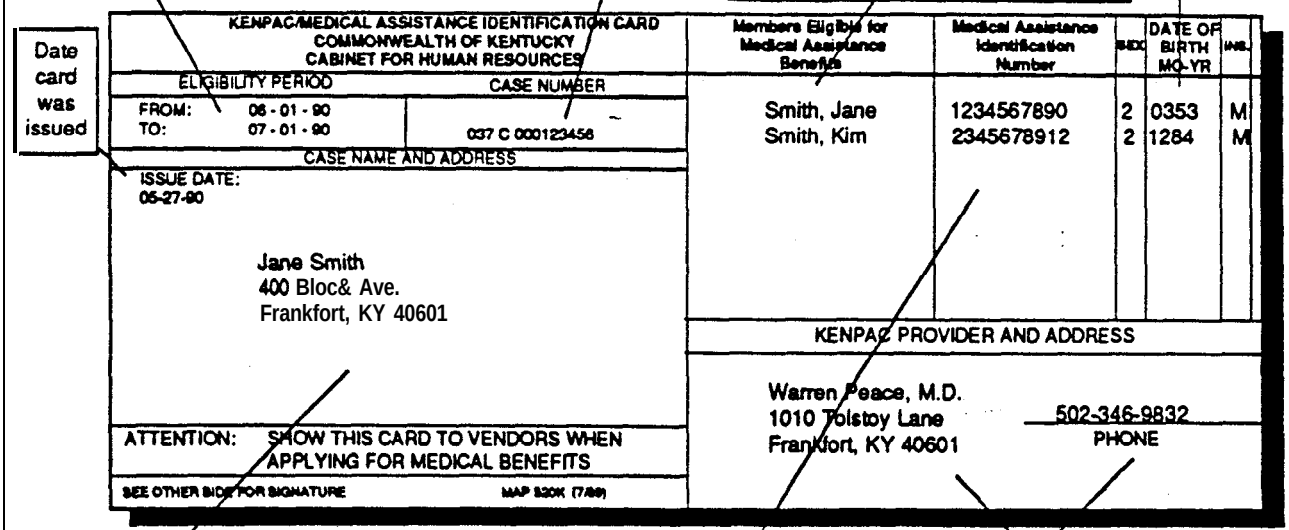
(FRONT OF CARD)

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care provider listed on this card.

Names of members eligible for Kentucky Medicaid. Persons whose names are in this block have the Primary Care provider fisted on this card.




Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care provider.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

# GREEN CARD

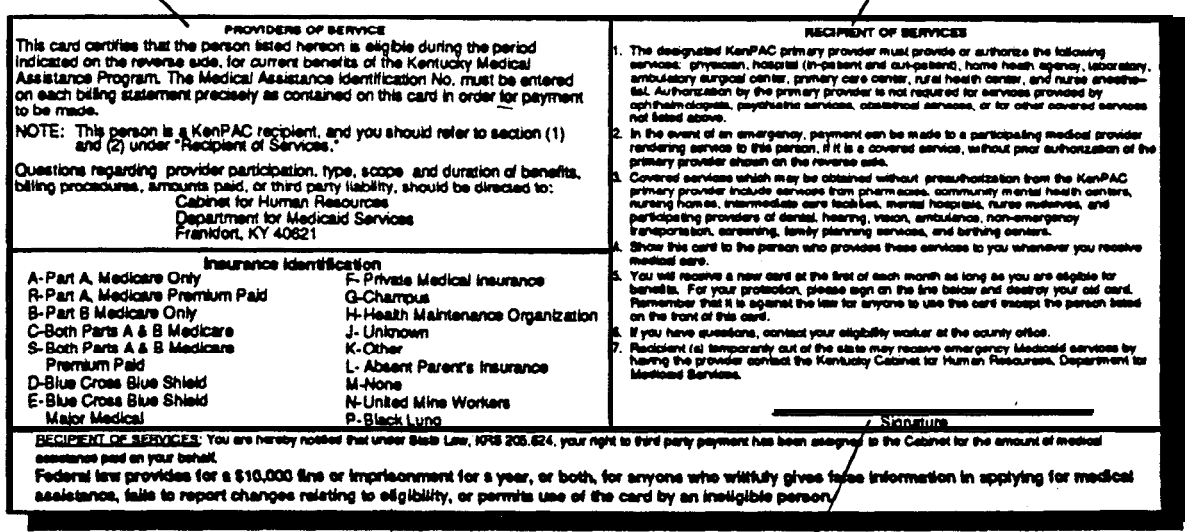
**CABINET FOR HUMAN RESOURCES**
**DEPARTMENT FOR MEDICAID SERVICES**

## KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.



**PROVIDERS OF SERVICE**

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:
Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

**Insurance Identification**

A-Part A, Medicare Only
R-Part A, Medicare Premium Paid
B-Part B Medicare Only
C-Both Parts A & B Medicare
S-Both Parts A & B Medicare Premium Paid
D-Blue Cross Blue Shield
E-Blue Cross Blue Shield Major Medical
F-Private Medical Insurance
G-Champus
H-Health Maintenance Organization
J-Unknown
K-Other
L-Absent Parent's Insurance
M-None
N-United Mine Workers
P-Black Lung

**RECIPIENT OF SERVICES**

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (in-patient and out-patient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, and nurse anesthetist. Authorization by the primary provider is not required for services provided by ophthalmologists, psychiatric services, obstetrical services, or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

**Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.**

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

MAP-344 (Rev. 3/91)

**Kentucky Medicaid Program**

**Provider Information**

1. _____ _____
(Name) (County)

2. _____
(Location Address, Street, Route No, P.O. Box)

3. _____
(City) (State) (Zip)

4. _____
(Office Phoned of Provider)

5. _____
(Pay to, In care of, Attention, etc.-If different from above address.)

6. _____
Pay to address (If different from above)

7. Federal Employee ID No. _____

8. Social Security No. _____

9. License No. _____

10. Licensing Board (If applicable): _____

Il. Original license date: _____

12. Kentucky Medicaid Provider No. (If known) _____

13. Medicare Provider No. (If applicable) _____

14. Practice Organization/Structure: (1) Corporation
_____ (2) Partnership ____(3) Individual
_____ (4) Sole Proprietorship ____ (5) Public Service Corporation
_____ (6) Estate/Trust ____ (7) Government/Non-Profit

15. Are you a hospital based physician (salaried or under contract by a hospital)? ____ yes ____ no
Name of hospital(s) _____

16. If **group practice, number of providers in group (specify provider type):**

_____

**17.** If **corporation, name, address, and telephone number of corporate office:**

_____

_____

**Telephone No:** _____

**Name and address of officers:**

_____

_____

_____

_____

**18. If partnership, name and address of partners:**

_____

_____

_____

_____

19. **National Pharmacy No. (If applicable):** _____
**(Seven-digit number assigned by the National Council for Prescription Drug Programs.)**

**20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):**

1st _____ **Date** _____

**2nd** _____ **Date** _____

**21. Name of Clinic(s) in which Provider is a member:**

**1st** _____

**2nd** _____

**3rd** _____

**4th** _____

**22. Control of Medical Facility:**

___ **Federal** ___ **State** **County** ___**City**
___ Charitable or **religious**
**Proprietary (Privately-owned)** ___ **Other**

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:

_____

_____

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:

_____

Member: _____

Member: _____

30. Management Firm (If applicable):

_____

31. Lessor (If applicable):

_____

32. Distribution of beds in facility:

| | Total Licensed Beds | Total Kentucky Medicaid Certified Beds |
|---|---|---|
| Acute Care Hospital | _____ | _____ |
| Psychiatric Hospital | _____ | _____ |
| Nursing Facility | _____ | _____ |
| MR/DD | _____ | _____ |

33. NF or MR/DD owners with 5% or more ownership:

Name Address % of Ownership

_____

_____

_____



TRANSMITTAL #1

34. **Institutional Review Committee Members** (If applicable):

_____

_____

35. **Providers of Transportation Services:**
**Number of Ambulances in Operation:** ___
**Number of Wheelchair Vans in Operation:** ___
**Basic Rate** $_____ (Includes up to ___ miles)
**Per Mile** $_____ Oxygen $_____
**Extra Patient** $_____ **Other** $_____

36. **Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider?** ___ yes ___ no

37. **Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.**

**Signature:** _____

**Name:** _____

**Title:** _____

**Return all enrollment forms, changes and inquiries to:**

**Medicaid-Provider Enrollment**
**Third Floor East**
**275 East Main Street**
**Frankfort, KY 40621**

**INTER-OFFICE USE ONLY**
**License Number Verified through** _____ **(Enter Code)**

**Comments:** _____

_____

**Date:** _____ **Staff:** _____

MAP-343 (Rev. 5/86)

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19__, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSE.TH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which-this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

| PROVIDER | CABINET FOR HUMAN RESOURCES<br>DEPARTMENT FOR MEDICAID SERVICES |
|---|---|
| BY: _____<br>Signature of Authorized Official | BY: _____<br>Signature of Authorized Official |
| NAME: _____ | NAME: _____ |
| TITLE: _____ | TITLE: _____ |
| DATE: _____ | DATE: _____ |

[redacted]

FORM APPROV
OMB NO 0938-(

# HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

form HCFA-1500 (I-84) Form OWCP-1500

Form CHAMPUS-501 Form ARE-1500

☐ MEDICARE (MEDICARE NO ) ☐ MEDICAID (MEDICAID NO, ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO ) ☐ FECA BLACK LUNG (SSN) OTHER c I (CERTIFICATE SSN) ☐ BLUE SHIELD

## PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2 PATIENT'S DATE OF BIRTH

3 INSURED'S NAME (LAST NAME FIRST NAME, MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5 PATIENT'S SEX MALE ☐ ☐ FEMALE

6 INSURED'S I D NO (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS)

7 PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8 INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO )

TELEPHONE NO

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO

A PATIENT'S EMPLOYMENT YES ☐ ☐ NO

B ACCIDENT AUTO ☐ ☐ OTHER

11 INSURED'S ADDRESS (STREET CITY STATE ZIP CODE)

TELEPHONE NO

11a CHAMPUS SPONSOR S

STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED

BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

## PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES

16a IF EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e g PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1 2 3 ETC OR Dx CODE

1
2
3
4

B

EPSDT YES ☐ ☐ NO

FAMILY PLANNING YES ☐ ☐ NO

PRIOR AUTHORIZATION NO

| 24 A DATE OF SERVICE FROM TO | B * PLACE OF SERVICE | C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY ) | (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) | D DIAGNOSIS CODE | E CHARGES | F DAYS OR UNITS | G * T O S | H LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO

27 TOTAL CHARGE

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO

32 YOUR PATIENT'S ACCOUNT NO

33 YOUR EMPLOYER I D NO

I D NO

*PLACE OF SERVICE AND TYPE OF SERVICE (T O S ) CODES ON THE BACK

REMARKS

TRANSMITTAL #1

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

34

35. MAKE PAYMENT TO Supervisor Physician

36 CLAIM NO

# REGIONAL INTERAGENCY COUNCIL
# CHECKLIST FOR IDENTIFICATION OF
# CHILDREN WITH SEVERE EMOTIONAL DISABILITIES

1. _____
Child's full name

2. _____
Child's social security number

3. _____
DSM III-R Diagnosis (Required)

AS stated in KRS 200.503, the child must present with one of the following conditions.

PLEASE CHECK THE EXISTING CONDITIONS

☐ (1) Presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas:

- ☐ (a) Self care: Defined as the ability to provide, sustain, and protect himself at a level appropriate to his age;
- ☐ (b) Interpersonal relationships: Defined as the ability to build and maintain satisfactory relationships with peer and adults;
- ☐ (c) Family life: Defined as the capacity to live in a family or family type environment;
- ☐ (d) Self direction: Defined as the child's ability to control his behavior and to make decisions in a manner appropriate to his age, and;
- ☐ (e) Education: Defined as the ability to learn social and intellectual skills from teachers in an educational setting;

OR

☐ (2) Is a Kentucky resident and is receiving treatment for emotional disturbance through the interstate compact;

OR

☐ (3.) The Department for Social Services has removed the child from the child's home and has been unable to maintain the child in a stable setting due to behavioral or emotional disturbance;

OR

☐ (4) A child who presents impairment/behavior of short duration yet of high intensity. Included are severe emotional problems such as suicidal or psychotic trauma reactions where prognosis regarding duration of symptoms cannot be accurately assessed.

This child is certified to meet the criteria as established above. Documentation of the existence of these conditions is present in the client record.

_____ _____
Authorized Agency Representative Date

Based on the information cited above, this child is hereby identified by the Regional Interagency Council as a "severely emotionally disturbed child" in need of case management services.

_____ _____
RIAC Chairperson Date

TRANSMITTAL #1

AS OF 08/01/91 KENTUCKY MEDICAID TITLE XIX REMITTANCE STATEMENT Page 1

RA NUMBER PROVIDER NAME
RA SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE:

* PAID CLAIMS *

| INVOICE NUMBER | -RECIPIENT IDENTIFICATION- NAME | NUMBER | INTERNAL CONTROL NC. | CLAIM SVC. DATE | TOTAL CHARGES | CHARGES NOT COVERED | AMT. FROM OTHER SOURCES | CLAIM PMT AMOUNT | EOB |
|---|---|---|---|---|---|---|---|---|---|
| 023104 | DONALDSON R | 3834042135 | 9883324-552-580 | 070191-073191 | 200.00 | 0.00 | 0.00 | 200.00 | 061 |
| 01 PS 1 | PROC X0064 | QTY 1 | | | | 0.00 | | | |

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 200.00 TOTAL PAID: 200.00

APPENDIX VII Page 1

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE:

IPTION OF EXPLANATION CODES LISTED VE

061 PAID IN FULL BY MEDICAID
254 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260 ELIGIBILITY DETERMINATION IS BEING MADE
365 FEE ADJUSTED TO MAXIMUM ALLOWABLE
999 REQUIRED INFORMATION NOT PRESENT

AS OF 08/01/91 KENTUCKY MEDICAID TITLE XIX REMITTANCE STATEMENT 

RA NUMBER PROVIDER NAME
RA SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE:

* RETURNED CLAIMS *

| INVOICE NUMBER | -RECIPIENT NAME | IDENTIFICATION- NUMBER | INTERNAL CONTROL NC. | CLAIM SVC. DATE | EOB |
|---|---|---|---|---|---|
| 324789 | SMITH | 4838021143 | 9883324-552-060 | 070191 | 999 |

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

| | CLAIMS PAID/DENIED | CLAIMS PD AMT. | WITHHELD AMOUNT | NET PAY AMOUNT | CREDIT AMOUNT | NET 1099 AMOUNT |
|---|---|---|---|---|---|---|
| CURRENT PROCESSED | 2 | 400.00 | 0.00 | 400.00 | 0.00 | 400.00 |
| YEAR-TO-DATE TOTAL | 30 | 6000.00 | 6000.00 | 6000.00 | 0.00 | 6000.00 |

TRANSMITTAL #1

AS OF 08/01/91 KENTUCKY MEDICAID TITLE XIX REMITTANCE STATEMENT 

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE:

* CLAIMS IN PROCESS *

| INVOICE NUMBER | -RECIPIENT IDENTIFICATION- NAME | NUMBER | INTERNAL CONTROL NC. | CLAIM SVC. DATE | TOTAL CHARGES | EOB |
|---|---|---|---|---|---|---|
| 023104 | JOHNSON P | 2471340401 | 9883342-564-210 | 070191-073191 | 200.00 | 260 |
| 574632 | MITCHELL J | 4331740410 | 9883347-575-240 | | 200.00 | 260 |

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 400.00

# PROVIDER INQUIRY **FORM**

**EDS**
P.O. Box 2009
Frankfort, Ky. 40602

Please remit both copies of the Inquiry Form to **EDS.**

| | | |
|---|---|---|
| 1. Provider Number | 3. Recipient Name (first. last) | |
| 2. Provider Name and Address | 4. Medical Assistance Number | |
| | 5. Billed Amount | 6. Claim Service Dale |
| | 7. AA Dale | 8. Internal Control Number |

9. Provider's Message

10. _____
Signature Date

Dear Provider:

This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim. Please resubmit.

This claim paid on _____ in the amount of _____

We do not understand the nature of your inquiry. Please clarify.

_____ EDS can find no record of receipt of this claim in the last 12 months.

This claim was paid according to Medicaid guidelines.

This claim was denied on _____ with EOB code _____

Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to beconsidered for payment.

Other: _____

_____
EDS Date

MAIL TO: EDS FEDERAL CORPORATION
P. 0. BOX 2009
FRANKFORT. KY 40602

ADJUSTMENT REQUEST FORM

| 1. Original Internal Control Number (I.C.N.) | EDS FEDERAL USE ONLY | | |
|---|---|---|---|
| 2. Recipient Name | 3. Recipient Medicaid Number | | |
| 4. Provider Name/Number/Address | 5. From Date Service | 6. To Date Service | |
| | 7. Billed Amt. | 8. Paid Amt. | 9. R.A. Date |

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or Incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature

13. Date

EDSF USE ONLY--DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

(REV. 7/91)

APPESDIX X

# THIRD PARTY LIABILITY
# LEAD FORM

Recipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address : _____

Policy #: _____ Start, Date: _____ End Date: _____

Date Filed with Carrier : _____

Provider Name : _____ Provider #: _____

Comments: _____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

# ASSURANCE OF CASE MANAGEMENT SERVICES CERTIFICATION FORM

## I. CLIENT INFORMATION

Client's Name _____ Birthdate _____

Medical Assistance Identification Number _____

Address of Client _____

Responsible Party/Legal Representative _____

Address _____

---

## II. CERTIFICATION

Targeted Case Management Services - This is to certify that I/responsible party/legal representative have been informed of my rights with regard to Case Management Services.

I elect ____ or do not elect ____ case management services.

I choose _____ as my Case Management Provider.

I choose _____ as my Case Manager.

_____ _____

Signature Date

Signature and Title of Person Assisting with Completion of Form _____

Agency _____

Address _____

MAIL TO: EDS
P.O. Box 2009
FRANKFURT, KY 40602

CASH REFUND DOCUMENTATION

1. Check Number

12. Check Amount

3. Provider Name/Number/Address

4. Recipient Name

5. Recipient Number

6. From Date of Service

17. To Date of Service

18. RA bate

9. Internal Control Number (If several ICNs attach RAs)

Reason for Refund: (Check appropriate blank)

___ a. Payment from other source - Check the category and list name (attach a copy of EOB)
Health Insurance
-Auto Insurance
___ Medicare paid
___ Other

___ b. Billed in error

___ c. Duplicate payment (attach a copy of both RA's)
If RA's are paid to 2 different providers specify to which provider number the check is to be applied.

___ d. Processing error OR Overpayment

Explain why

___ e. Paid to wrong provider

___ f. Money has been requested - date of the letter / /
(Attach a copy of letter requesting money) - - -

___ g. Other

Contact Name Phone:

NOTE: Persons employed as Case Managers as of July 1, 1991, (the implementation date of this program) shall be considered "grandfathered", with regard to the one (1) year of experience requirement; however, the minimum educational requirement must be met. Anyone appointed to a case management position on or after July 1, 1991, shall meet the experience requirement.

(3) Completed a case management certification or training course, provided by the Department for Mental Health/Mental Retardation or the Department for Social Services, within six (6) months of his employment date; and

**(4)** In addition to the above, the case manager shall be supervised for one (1) year by a mental health professional; i.e. psychiatrist, psychologist, Master's level Social Worker (MSW), psychiatric nurse, or professional equivalent. A professional equivalent is defined as staff who have at least a Bachelor's degree in a behavioral science and two (2) years of experience in providing children's services. The supervisor shall also complete the required case management certification or training course.

Supervision is to be performed at least once a month, both individually (per client treatment plan) and in group (resource development).

**(5)** Case managers shall deliver only case management services, whether ***or*** not they are employed by the case management provider on a part-time or full-time basis.

**(6)** The recommended case load size is **15-20:1** for a full-time case manager. [~~with no more than ten (10) intensively case-managed children at one time.~~] The maximum case **load size shall'be 25.**

D. Regional Interagency Council (RIAC)

(1) Identification

All children seeking case management services under the Targeted Case Management Program shall be identified as severely emotionally disturbed (SED) children by the RIAC.

The agency referring the child to the RIAC for review is responsible for documenting that the child meets the-criteria as stated in Section III, D. Client Qualifications of this manual.

An authorized representative from the referring agency shall sign the RIAC Form MAP-~~[3]~~5**85** (See Appendix VI) as certification of the child's condition. The RIAC will review the completed MAP-~~[3]~~5**85.** The signature of the RIAC chairperson on the MAP-~~[3]~~5**85** will certify that the child has been identified as an SED child by **the RIAC.**

(2) Emergency Services

In the event of an emergency (i.e. a child is in need of emergency case management services but the RIAC, due to meeting only monthly, does not meet timely enough to identify the child prior to needed services being rendered), the referring agency may.provide case management services for up to four (4) weeks without the completion of the RIAC MAP-~~[3]~~5**85** form. However, if the child is not identified by the RIAC at its next monthly meeting as an SED child, the referring agency may be at risk of providing services without receiving reimbursement.

(3) Documentation of Client Qualifications

It is the responsibility of the referring agency or other chosen case management provider to maintain all documentation regarding the child's DSM-III diagnosis, the RIAC MAP-[+]585 form, and any other records that support the decision to provide Targeted Case Management Services for a particular child.

E. Assurance of Case Management Services Certification MAP-~~[3]~~586 Form

After a child has been identified as an SED child by the RIAC, the referring agency or other.chosen case management provider shall complete a MAP-~~[3]~~586 Form. This form assures that the client has had freedom of choice of not only case management services, but also a choice of all participating case management providers and case managers within a provider group, if applicable.

The referring agency, if chosen as the case management provider, shall retain a copy of this form in the client's files. A copy is to be given to the child's legal guardian or person in custodial control. If the referring agency assisting with completion of the form is not the chosen case management provider, the chosen provider shall retain a copy of the MAP-~~[3]~~586 form in the client's file.

F. Out-of-Region or Out-of-State Short Term Placements

Children who meet all the requirements for targeted case management services and who are placed in out-of-region or out-of-state temporary or short term placements may be continued to be case managed by their "home" case management provider.

The requirement of four (4) service contacts per month is still required; at least one (1) contact shall be a face-to-face encounter with the child. However, it is recognized that a face-to-face encounter with the child in such placements may be difficult.

V. Reimbursement

A. Payment

Reimbursement for Targeted Case Management Services for SED children shall be a cost-based system, utilizing an interim rate based on projected cost during the first year, with a year-end cost settlement. This methodology shall be reassessed prior to the beginning of year two.

Payment shall be made when four (4) service contacts have occurred during a month. Two (2) of the contacts shall be face-to-face; at least one (1) contact shall be with the child and the other with the parent or family or person in custodial control. The other two (2) contacts may be telephone or face-to-face contacts with or on behalf of the child. If there should be situations whereby multiple contacts are made on the same day, then the following procedures will be used: (1) if contacts are directly inter-related then all contacts would be counted as one contact; (2) If contacts are not directly interrelated then contacts would be counted as two contacts.

The unit of service shall be defined as one unit equaling one (1) month. The interim rate, for year one, shall be based on the provider's usual, customary, and reasonable charge up to a- maximum of $200.00 per child per month. No more than one (1) payment per child per month shall be made and this payment shall represent payment in full for all case management services provided to the child during a month. The payment amount shall not vary with the nature or the extent of the case management services being provided. The charge to the Medicaid Program shall be the same for all persons who receive the same or similar service.

Appropriate documentation shall be maintained in the child's record of all case management services billed and performed.

## SECTION VI - COMPLETION OF CLAIM FORM

VI. Completion of Claim Form

A. General Information

1.. Claims shall be submitted on the standard "Health Insurance Claim Form," (HCFA-1500, (12/90) ~~[1/84]~~ . Information entered on this form must be data entered for the claim to be processed; therefore, it is important that all information supplied is complete and legible. Typing the claim form is recommended, although clear, legible handwriting is acceptable. Claims may also be submitted electronically. Contact EDS to obtain instructions on how to bill electronically.

According to Federal policy, claims shall be submitted to Medicaid within twelve (12) months of the date of service or within six (6) months of the Medicare payment date, whichever is longer.

2. Billing Instructions for Claims with Service Dates Over One Year Old

Medicaid claims shall be filed within one (1) year of the date of service. Medicaid/Medicare crossovers shall be filed within one (1) year of the date of service OR within six (6) months of the Medicare paid date, whichever is longer. To process claims beyond this limit you must attach, to EACH claim form involved, a copy of an in-process, paid, or denied claim remittance no more than twelve (12) months of age which verifies that the original claim was submitted within twelve (12) months of the service date.

Copies of previously submitted claim forms, providers' in-house records of claim submittals, and letters which merely detail filing dates are NOT acceptable documentation of timely billing. Attachments shall prove that the claim was RECEIVED in a timely manner by EDS.

If a claim is being submitted after twelve (12) months from the date of service, due to the recipient's retroactive eligibility, a copy of the backdated or retroactive MAID card shall be attached to the claim form.

3. MAID Number

The client's Kentucky Medicaid Identification (MAID) card should be checked carefully to verify the ten (10)-digit MAID number, the client's name, and that the card is valid for the period of time during which services are provided. "Eligibility Period" on the MAID card may show month-to-month eligibility (e.g. from 07/01/91 to 08/01/91), retroactive eligibility (e.g. from 06/01/90 to 08/01/91), or specific dates of eligibility (e.g. from 07/20/91 to 08/01/91). The "To" date is not an eligible date. Payment cannot be made for services provided to an ineligible person.

4. Medicaid Provider Number

All provider records, including Remittance Statements and payments, are maintained by the computer system by provider number. The correct eight (8)-digit Kentucky Medicaid Provider Number shall be entered on the claim form in field #33 of the HCFA-1500 (12/90) ~~[(1/84)]~~ form to ensure notification of the status of the claims and correct payment. An incorrect or missing number could result in payment to another provider if the number is a valid provider number, or failure of the claim to receive payment. Since the Remittance Statements contain information about claims by provider number, claims with invalid provider numbers will not appear on Remittance Statements.

~~Claims shall be returned or rejected if the REQUIRED information is incorrect or omitted. The following items shall be completed~~:

[ITEM NO. ITEM DESCRIPTION

~~1.~~ ~~PATIENT'S NAME~~

~~Enter the client's last name, first name, and middle initial exactly as it appears on the current MAID card.~~

~~8.~~ ~~INSURED'S GROUP NO~~.

~~Enter the client's 10-digit MAID number exactly as it appears on the current MAID card~~.

~~9.~~ ~~OTHER HEALTH INSURANCE~~

~~Complete if the client has any kind of health insurance other than Medicare and Medicaid. Enter the name and address of the insurer and the policy number. The amount paid by the insurance company should be listed in item 28. Private insurance shall be billed prior to billing Medicaid.~~ ]

~~10.b.~~ ~~ACCIDENT~~

Check if diagnosis was the result of an accident.

~~16.a.~~ Check if illness or condition is an ~~emergency~~.

23. ~~DIAGNOSIS OR NATURE OF ILLNESS OR INJURY~~

~~Enter the DSM-III diagnosis code for the diagnosis that was treated. Do not enter more than three DSM-III diagnosis codes in 23~~.

## SECTION VI - COMPLETION OF CLAIM FORM

**24B** PLACE OF SERVICE

Enter the appropriate two (2)-digit place of service code. The place of service code for case management service is 99.

**24D** PROCEDURE CODE

Enter the five (5) digit procedure code X0064.

**24E** DIAGNOSIS CODE INDICATOR

Transfer "1", "2", "3", or "4" from field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.

**24F** PROCEDURE CHARGE

Enter your ususal and customary charge for case man agement services.

**24H** EPSDT FAMILY PLAN

Enter a "Y" if the treatment rendered was a direct result of the Early and Periodic Screening, Diagnosis and Treatment Program.

**26** PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key the first eight or fewer digits. This number will appear on the Remittance Statement as the invoice number.

**28** TOTAL CHARGE

Enter the total charges from all lines of the claim.

**29** AMOUNT PAID

Enter the amount received by private insurance. If no private insurance payment, leave blank.

24A. DATE OF SERVICE

Enter the date of service. for example 07/01/91-07/31/91. The "From" date of service entered shall be the date the initial service was provided and the "To" date of service shall be the last day of the month.

Do not enter more than one month of service per line.

24.B. PLACE OF SERVICE

Use place of service code 0 (zero) for all case management services.

24.C. PROCEDURE CODE

Enter the five (5) digit procedure code X0004.

24.D. DIAGNOSIS CODE

Transfer a 1, 2, or 3 from item 23, to indicate which diagnosis is being managed. DO NOT enter the actual DSM-III diagnosis code in this blank.

24.E. CHARGES

Enter your usual and customary charge for case management services.

24.F. DAYS OR UNITS

Enter one (1) unit per month of service.

25. SIGNATURE OF PROVIDER

The signature of the individual authorized to sign on behalf of the provider is entered here. Stamped signatures are not acceptable.

DATE

Enter the numeric date the claim is submitted. Use month-day-year order, for example 07/31/91.

## SECTION VI - COMPLETION OF CLAIM FORM

30 BALANCE DUE

Enter the amount received form Medicare, if any, otherwise. leave blank.

31 SIGNATURE/INVOICE DATE

The actual signature of the provider or the provider's appointed representative is required. Stamped signatures are not acceptable.

33 PROVIDER NUMBER

Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight (8)-digit individual Medicaid provider number.

Send the completed original HCFA-1500 (12/90) claim form to EDS for processing as soon as possible after the service is provided.. Retain a copy in your' files.

Mail completed claims to:

EDS
P.O. Box 20'18
Frankfort, Ky 40602

27. TOTAL CHARGE

Enter the total charges from all lines of the claim.

28. AMOUNT PAID

Required if private insurance payment was made. Enter the private insurance payment here.

29. Balance Due

Subtract the private insurance payment (Block 28) from the total charge (Block 27) and enter the difference here.

31. PROVIDER NAME, ADDRESS, AND MEDICAID PROVIDER NUMBER

Enter the provider's name, address, zip code.

I.D. NO.

Enter the provider's 8-digit Medicaid provider number.

36. CLAIM NO.

Enter the claim number or client number, if desired. EDS will key the first seven or fewer digits. This number shall appear on the Remittance Statement.

Send the completed original HCFA-1500 (1/84) claim form to EDS for processing as soon as possible after the service is provided. Retain a copy in your files.

Mail completed claims to:

EDS
P.O. Box 2018
Frankfort, Kentucky 40602